REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive** **James Paget University Hospital NHS Foundation Trust** **Lowestoft Road** **Gorleston** **Great Yarmouth NR31 6LA**
1	**CORONER** I am DAVID OSBORNE, assistant coroner, for the coroner area of Norfolk
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 18 March 2014 I commenced an investigation into the death of Michael Barry Richardson aged 66 years. The investigation concluded at the end of the inquest on 18 March 2015. The conclusion of the inquest was that the medical cause of death was 1a Bronchopneumonia, 1b Pulmonary Fibrosis, 2 Pulmonary hypertension and Ischaemic Heart Disease and that Mr Richardson died from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Mr Richardson was admitted to the James Paget University Hospital on 24 October 2013 following a deterioration in his lung disease. He was diagnosed as suffering from an infective exacerbation of his pulmonary fibrosis and a community acquired pneumonia. Despite treatment he arrested and died on 27 October 2013. On admission a MUST screen was carried out by a student nurse with a score of 0.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – There was within Mr Richardson's records an ambulance crew report which recorded that Mr Richardson was said to have not eaten for 5 days. In evidence before me it was confirmed that the ambulance report would have been available to the person who undertook the MUST screen. It also appeared that this may not have been reviewed at the time. If it had been reviewed the evidence given before me was to the effect that the information might have led to a MUST score of 2 which would in turn have led to a referral to dietician services. Although the expert evidence was that Mr Richardson's nutrition did not play a material part in his death, I am nevertheless concerned that in different circumstances a failure to follow up information or review the ambulance record and/or any other records with which a patient is admitted and

	so miss the information could affect the outcome for the patient and that there is therefore a risk of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 May 2015. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] (wife) [redacted] (daughter) I have also sent it to the Department of Health who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**24 March 2015** ..... **David Osborne, Assistant Coroner**